WORKERS' COMPENSATION PREVIEW

State of California
Department of Personnel Administration

Workers' Compensation Program

January 2008

TABLE OF CONTENTS

WORKER'S COMPENSATION SYSTEM

What is Workers' Compensation?

The workers' compensation system provides benefits to employees for work-related injuries or illnesses. These benefits may include medical treatment costs, temporary disability payments for lost wages, permanent disability payments that compensate the injured employee for diminished future earning capacity, and death benefits.

All State employees are covered by workers' compensation. The cost of this protection is paid by the State of California, the employer. Workers' compensation benefits are tax free and are not subject to Social Security deductions.

The Historic Compromise

The workers' compensation system is designed to trade off rights and benefits between employers and employees. An injured employee gives up the right to pursue an award by suing the employer in civil court, in exchange for a system that is designed to provide prompt delivery of benefits and legal protection against discrimination. The employer provides no-fault workers' compensation coverage to all employees, and in exchange, the employer receives protection against related civil actions. In most cases, workers' compensation is the exclusive remedy for an employee who is injured on the job. This exchange, often called the "historic compromise," can be summarized by three components:

No Fault - The employer is required to pay benefits no matter who caused the injury, as long as the injury arose out of employment and in the course of employment.

Assured and Fixed Benefits - Workers' compensation awards are typically less than a comparable negligence award in a civil suit.

Exclusive Remedy – An injured employee can't pursue other forms of recovery from the employer, even if the employer was grossly negligent. (If there is a third party who caused the injury or death, such as in a work-related car accident, that third party may be sued.)

Laws and Regulations

The California Constitution, Article XIV, Section 4, authorizes the Legislature to establish a system of workers' compensation. Over the years, the Legislature has passed a body of laws that define eligibility, the types and levels of benefits, and the method of system operation. Most of these laws are in the California Labor Code (LC), although there are also relevant sections in the California Insurance Code.

Regulations are more specific than laws and govern the day-to-day operation of the workers' compensation system. Regulations contain information such as the time limits for filing documents, requirements for the contents of reports, and the procedures to follow

when appealing a ruling. The administrative body that develops regulations for the workers' compensation system is the Division of Workers' Compensation. When the Legislature changes the law, the Division of Workers' Compensation must change its' regulations to remain consistent with new law. State Personnel Board (SPB) Laws and Rules, the Department of Personnel Administration (DPA) Laws and Rules, and the State Administrative Manual (SAM) also govern State agencies.

Regulations are cited by title and section number. Most workers' compensation regulations are in Title 8 of the California Code of Regulations (CCR). For example, 8 CCR 9785 refers to section 9785 of the CCR.

How is Workers' Compensation Organized in State Government?

The Legislature has delegated the operation of the workers' compensation system to several departments within the executive branch of State government.

Division of Workers' Compensation (DWC)

The DWC, under the guidance of the Administrative Director, has overall responsibility for administering the workers' compensation system.

The DWC contains the following units:

Claims Adjudication Unit - Comprised of workers' compensation judges and their staff. These judges are the initial level of adjudication in workers' compensation claims.

Disability Evaluation Unit - Comprised of disability evaluators (also called disability raters), this unit determines permanent disability ratings based on the physician's impairment evaluation and the State's "Schedule for Rating Permanent Disabilities."

Information and Assistance Unit – Comprised of information and assistance officers who provide information to employees, employers, insurers, doctors, and attorneys regarding workers' compensation issues. These officers also assist in the prompt resolution of misunderstandings, disputes, and controversies arising out of workers' compensation claims.

Rehabilitation Unit – Determines services needed to assist injured workers to return to suitable gainful employment, and resolves disputes regarding rehabilitation benefits and services.

Audit and Enforcement Unit - Audits insurance companies, self-insured employers, and third-party administrators to ensure that they have met their obligations under the Labor Code and the Administrative Director's regulations.
Uninsured Employers' Fund and Collections Units - Pays benefits to injured employees whose employers are illegally uninsured and pursues recovery from these employers.

Medical Unit – Examines and appoints physicians to be qualified medical evaluators (QMEs), enact evaluation guidelines, and assists with issues affecting physicians and other providers in the workers' compensation system.

For additional information and resources provided by the DWC, please visit the following Web site address: www.dir.ca.gov/dwc.

Workers' Compensation Appeals Board (WCAB)

The WCAB is an independent judicial body within the Department of Industrial Relations (DIR). It is comprised of seven commissioners, five of whom must be attorneys and are appointed by the Governor. The WCAB adopts rules of procedure, sets policy, interprets regulations, and reviews petitions for reconsideration of decisions made by workers' compensation administrative law judges.

For additional information and resources provided by the DIR, please visit the following Web site address: www.dir.ca.gov.

Who Else is Involved in the Workers' Compensation System?

Workers' Compensation Program (WCP)

The Department of Personnel Administration's WCP manages the State's Master Agreement with State Compensation Insurance Fund (State Fund) to provide workers' compensation claims processing and legal representation. The Master Agreement is an Interagency Agreement. Insurance Code Section 11871 provides the authority for State Fund to contract with DPA and the departments for the provision of workers' compensation benefits and services. Activities include technical training, departmental program audits, advice and consultation, and design of new programs.

For additional information and resources provided by the WCP, please visit the following Web site address: www.dpa.ca.gov/benefits/health/workcomp/wcmain.shtm

State Compensation Insurance Fund (State Fund)

State Fund is the claims administrator for the State of California's agencies, departments, boards, and commissions who are legally uninsured under the Master Agreement. The agreement enables the participant departments, in partnership with State Fund and DPA, to provide all benefits to which their injured employees are lawfully entitled. Under the agreement, State Fund acts as the State of California's adjusting agent and the individual State departments are responsible for the costs associated with workers' compensation claims. For additional information and resources provided by State Fund, please visit the following Web site address: www.scif.com/statecontracts/
NOTE: Not all State of California agencies, departments, boards, and commissions are participants in the Master Agreement. A number of the departments have opted to

purchase an insurance policy to cover the risks inherent to the workers' compensation system.

Return-to-Work Coordinator (RTWC)

Each State department has someone designated as the RTWC, Departmental Claims Coordinator, or departmental designee. This person is responsible for managing the workers' compensation cases for the department. This person is responsible for advising supervisors and employees on the workers' compensation process and the benefits to which an injured employee may be entitled. In addition, the RTWC is responsible for assisting injured employees in returning to work as soon as medically feasible.

Physicians

The workers' compensation system defines two types of physicians: the primary treating physician and the evaluating physician.

Primary treating physician – has the responsibility for providing an injured employee with the medical treatment necessary to cure or relieve the effects of a work-related injury or illness. A primary treating physician can be a medical doctor, licensed psychologist, chiropractor, optometrist, dentist, or other specialist. There can only be one primary treating physician at a time. If necessary, the primary treating physician may refer the injured employee to a consulting physician.

Evaluating physician - provides medical evidence that is used to resolve disputes over the compensability of a claim, need for treatment, temporary disability status, permanent disability, or medical eligibility for vocational rehabilitation services. A Qualified Medical Evaluator (QME), Agreed Medical Evaluator (AME), or Independent Medical Examiner (IME) may serve as an evaluating physician.

Attorneys

Any party involved in a workers' compensation claim may be represented by an attorney. If an injured employee hires an attorney, the fees will be deducted from any award that he or she might receive, unless the WCAB decides that no compensation is payable. The fees that an attorney can charge an injured employee are limited and are determined by the workers' compensation judge. The attorney representing an injured employee is called the applicant's attorney. The attorney representing an employer is called the defense attorney. State Fund has a litigation unit dedicated to representing participant departments on their workers' compensation claims.

Qualified Rehabilitation Representatives (QRR)

A qualified rehabilitation representative (QRR) is an independent vocational counselor, assigned to a case when an injured employee accepts vocational rehabilitation services (applies to injuries occurring before 1/1/2004). The QRR is agreed upon by both State Fund and the injured employee or his or her attorney. If an agreement can't be reached, an independent vocational evaluator will be assigned by the DWC's rehabilitation unit. The QRR will determine if the injured employee is vocationally feasible, which means that he or she is reasonably expected to return to suitable gainful employment. When making this determination the QRR will take into consideration the medical documentation, which stated that the injured employee is medically eligible for vocational rehabilitation services. If the injured employee is both medically eligible and vocationally feasible for services then he or she is considered a qualified injured worker (QIW). The QRR will work with the injured employee to develop a vocational rehabilitation plan, which may include modified or alternative work, job placement, retraining, on-the-job training, or self-employment

How a Disability Claim is Filed and Processed

California law imposes strict work-related injury reporting requirements on both the injured employee and the employer. The injured employee, his or her immediate supervisor, the second line supervisor or manager, and the personnel office share responsibility for timely and adequate reporting of work-related injuries or illnesses. Without prompt accurate reporting, benefits may be delayed. A delay in the provision of benefits may result in awards for increased benefits (penalties) or interest charges assessed against your department.

Employee Responsibilities

Reporting the Injury or Illness

If an employee is injured or becomes ill as a result of his or her employment, he or she must report the injury to his or her supervisor as soon as possible. The supervisor will provide the employee with a *Workers' Compensation Claim Form & Notice of Potential Eligibility* form (DWC 1, SCIF 3301). The SCIF 3301 describes how, when, and where the injury occurred. The SCIF 3301 must be provided to the employee for injuries or illnesses that result in lost time beyond the work shift on the date of injury or require medical treatment beyond first aid.

Obtaining Treatment

If the injured employee predesignated a personal physician or medical group, in writing, prior to the date of injury they may elect to go to that physician or medical group for treatment immediately after an injury. The *Guide to Workers' Compensation for New State of California Employees* pamphlet (SCIF 13546) includes a form that an employee can use to predesignate a personal physician or medical group.
Otherwise, the department is responsible for arranging treatment at an appropriate employer selected physician or medical facility. If the department

has not posted the *Notice to Employees* (SCIF e13913/ e13914) in a conspicuous place and listed the physician and emergency hospital that your department selected to provide care for your injured workers, then your injured worker may choose his or her own physician (even if there is no predesignation form on file). It is important to inform the treating physician that the employee's injury or illness is work related.

Absence Reporting

After receiving treatment for the injury, the injured employee must inform his or her supervisor of the physician's advice concerning his or her ability to resume work responsibilities. All time off related to the injury must be reported on the *Absence and Additional Time Worked Report* form (STD. 634). Although, no time is charged against leave credits on the day of injury, a notation must be made to show the date of injury on the STD. 634. A statement from the attending physician is required each time the injured employee is seen regarding the work-related injury or illness. All physician statements must be attached to the STD. 634 and either forwarded to the attendance clerk or personnel office.

Supervisor's Responsibilities

Assuring Prompt Medical Treatment

In the event of an on-the-job injury, a supervisor must ensure employees receive prompt and proper medical care if such care is believed necessary by either the supervisor or the employee.

For injuries requiring immediate emergency assistance, dial 911 (or 9-911, if your office requires that you dial 9 for an outside line). If needed, have a trained individual administer first aid or CPR. If emergency treatment is not needed but it appears that medical treatment is required, arrange for treatment by an employer-selected physician. This physician is listed on the *Notice to Employees* poster (SCIF e13913/e13914) or equivalent form.

Note: If your injured employee is referred to an employer selected physician, they must be given the *Guide to the State Fund Medical Provider Network for State of California Employees* brochure (SCIF e13174). An appointment for non-emergency medical treatment must be made for the injured employee within three working days from your department's notice of an injury or within one working day after the claim form is filed. For information regarding your department's Medical Provider Network (MPN) process contact your department's Personnel Office or designated MPN contact.

If an employee has predesignated a treating physician or medical group, the employee has the right to seek medical treatment with that physician or group. The employee must have given the department written notification of the name of the physician or group prior to the date of injury. The supervisor or designee is responsible for accompanying the injured employee to the doctor. The

Personnel Office should be notified as soon as possible when an employee has been injured on the job.

While at the doctor's office, the supervisor should find out from the doctor if the injured employee will be able to return to work. If the employee is not able to return to work immediately, find out how long the employee will be off work. A description of the employee's normal duties, or of alternate "light duty" work that may be available, may help the doctor make a decision.

Reporting the Injury or Illness

The supervisor or designee must provide the injured employee with the SCIF 3301, within one working day of knowledge of the injury or illness. The injured employee may also be provided with the, *I've Just Been Injured on the Job, What Happens Now?* Brochure, available at: www.dpa.ca.gov/benefits/health/workcomp/wcmain.shtm. The SCIF 3301 does not need to be provided for injuries that do not result in lost time beyond the employee's work shift or requiring treatment beyond first aid, unless the employee requests one.

First aid is defined as any one-time treatment, and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, and so forth, which do not ordinarily require medical care. Such one-time treatment and follow-up visit for the purpose of observation is considered first aid even if provided by a physician or registered medical personnel.

When the injured employee returns the SCIF 3301, give the "employee's temporary copy" to him or her and then complete the employer's section. Once the form is completed, the supervisor is to give the employee his or her copy and forward the remaining form to the departmental RTWC or departmental designee. The employer is required to provide SCIF with the completed SCIF 3301 within five calendar days of receipt.

Note: Once a completed SCIF 3301 has been received from the injured employee, authorization for medical treatment must be given within one working day. Employers are responsible for paying up to $10,000 in medical treatment until a claim is denied. If a claim is accepted medical treatment will continue to be paid by the employer.

The supervisor or designee must also complete the *Employer's Report of Occupational Injury or Illness* form (SCIF 3067). This form must be received by SCIF within five days of your department's knowledge of an injury or illness. The SCIF 3067 must be completed if the injured employee has lost time beyond the date of injury or illness or medical treatment beyond first aid was provided or the employee has completed and returned a SCIF 3301.

Maintain Contact

The supervisor or appropriate designee shall maintain frequent contact with the injured employee and arrange for the injured employee to return-to-work as soon as it is medically feasible. The supervisor or appropriate designee is also responsible for providing information to the second line supervisor or manager, the personnel office, and RTWC regarding the status of the injured employee.

Reviewing Supervisor/Manager's Responsibilities

The second line supervisor or manager reviews the information provided on SCIF 3067 for accuracy and completeness. If there is any question or doubt that the injury or illness is work related, a memorandum may be attached to the SCIF 3067 describing the facts as they are known and a request made for further investigation by State Fund. The law requires that this form be sent to State Fund within five calendar days of the employer's knowledge of an injury. Filing late reports could cause a delay in the injured employee receiving benefits, which could result in awards for increased benefits (penalties).

Personnel Office Responsibilities

Notify Employee of Benefit Options

For dates of injury occurring on or after January 1, 1993, the personnel office is required to send the injured employee an *Industrial Disability Leave with Supplementation Information and Benefits Option Selection* form (STD. 618S). The personnel office is required to send the STD. 618S within 15 days of the date State Fund notifies the department that a claim is accepted and worker's compensation benefits are approved.

The employee has 15 days to choose whether or not they would like to supplement their Industrial Disability Leave (IDL) benefit. The election period commences on the date the injured employee receives the STD. 618S. If the injured employee fails to make a timely election then they will be placed on IDL without supplementation and forfeit the right to supplement IDL at any future time. The personnel office cannot advise an injured employee of which benefit option to select, but can answer questions regarding the options available.

The *Temporary Disability Verification of State Employees* form (SCIF 3290) or a notification letter from State Fund is used to notify the departments of claim acceptance. This form lists the dates and hours State Fund has verified as disability periods related to the injury and authorizes the personnel office to request the release of IDL benefits.

Please refer to publication entitled *Workers' Compensation Claims Kit: Instructions for Completing the Forms Required to Report a Work-Related Injury or Illness*. This publication is available online at www.dpa.ca.gov/benefits/health/workcomp/wcmain.shtm

Recommended Routing Instructions for Completed Forms

Every department has internal procedures for reporting a work-related injury or illness. Please follow your departmental procedures in conjunction with the use of this guide.

FORMS	COPIES	TO
SCIF 3301	Original	State Fund
	Employer's copy	Health and Safety/Workers' Compensation Unit
	Employee's copy, Employee's Temporary Receipt, and *Notice of Potential Eligibility*	Employee
SCIF 3067	Original	State Fund
	Copy	Reporting Unit File
	Copy	Health and Safety/Workers' Compensation Unit

What Actions Does State Fund Take Once Notified of An Injury?

Once State Fund is notified that an injury or illness has occurred they will establish a workers' compensation claim. State Fund is required to send notification to the employee on whether the claim has been delayed, accepted, or denied within 14 days from the employer's date of knowledge of the injury or illness. State Fund makes all liability determinations based on available medical documentation and relevant facts.

If a claim is *delayed*, State Fund is in need of additional information in order to make its' liability determination. State Fund has 90 days from the employer's date of knowledge to make a final determination. If a completed SCIF 3301 has been returned then the employer must authorize medical treatment within one working day. The employer must pay for medical treatment up to $10,000 until a liability determination has been made. If the $10,000 cap is reached prior to a liability determination being made then the employee or his or her medical insurance carrier are responsible for paying the cost of any additional medical treatment that is received as a result of the injury or illness. The injured employee will not be compensated for any lost time from work during the delay period. If time from work is missed during the delay period, the injured employee should contact his or her personnel office to find out about other leave options that may be available. To gather more information, State Fund may request the injured employee to attend one or more medical evaluations. The injured employee will be asked to complete and sign medical release forms so that State Fund can obtain copies of his or her prior medical records. State Fund may also ask the employer to provide a copy of personnel records, a duty statement, etc. State Fund will use all relevant information to make a liability determination regarding the injured employee's claim.

If the claim is *accepted*, State Fund will pay for all approved medical treatment, hospital visits, and reasonable medical transportation. State Fund will reimburse the injured employee and his or her insurance carrier for approved medical treatment received prior to the acceptance of the claim. State Fund will require the injured employee to submit a receipt with any requests for reimbursement of out-of-pocket medical expenses (e.g., co-pay). The injured employee will be provided with all benefits to which he or she is legally entitled.

If the claim is *denied*, the injured employee and his or her medical insurance carrier will be responsible for the costs of any medical treatment received. When a claim is denied, the injured employee will not be provided with any type of compensation. If time was lost from work, the injured employee should contact his or her personnel office to discuss other leave options that may be available. If the injured employee agrees with the denial, the claim will be closed. If the injured employee disagrees with the denial, he or she has a right to dispute State Fund's determination. Options for disputing the determination are outlined in the denial letter that is sent to the injured employee by State Fund.

BASIC CONCEPTS

What is a Compensable Injury?

An employer must provide compensation, without regard to negligence, for "any injury sustained by his or her employee arising out of and in the course of the employment." Four basic conditions must be met for a workers' compensation claim to be established:

1. There must be an employment relationship;
2. There must be a medically substantiated "injury";
3. The injury must occur in the course of employment; and
4. The injury must arise out of employment.

The physician provides crucial input into the system by defining the injury and establishing whether, and how, the injury is related to the employment. Physicians do not usually provide information regarding the employment relationship or whether the injury occurred in the course of employment.

Exclusions

The following types of injuries are excluded from compensation (LC §3600):

- Caused by the injured employee's intoxication, by alcohol or illegal use of a controlled substance;
- Intentionally self-inflicted;
- Willfully and deliberately caused own death (suicide);
- Caused by an altercation where the employee was the initial aggressor;

- Caused by the injured employee's commission of a felony, for which he or she has been convicted (the 1993 workers' compensation reform added an exclusion for "wobbly felonies," that is crimes that may be prosecuted as misdemeanors or felonies); or
- Caused by participation in off-duty recreational activities, where participation in the activities does not constitute part of the injured employee's work-related duties;

What is an "Injury"?

An injury is defined to include:

- Any injury or disease arising out of employment (LC §3208);
- Any aggravation or acceleration, due to employment, of a pre-existing physical or mental condition or pathology (LC §4663);
- Any "derivative" injury caused by the treatment of an injury arising out of employment; and
- Any reaction to or side effect from preventive health care the employer provides to health care workers (LC §3208.05).

Injuries may be specific or cumulative. A specific injury occurs as the result of a single incident or exposure. A cumulative trauma injury results from repetitive trauma occurring over a period of time (LC §3208.1).

In order for a condition to be considered an injury, it must either cause disability or result in a need for medical treatment. A condition that causes no lost time from work, does not interfere with an injured employee's ability to work, or only requires first-aid treatment is not considered an injury within the workers' compensation system.

"First-aid treatment" is defined in LC §5401 as any one-time treatment and any follow up visit for the purpose of observation of minor scratches, cuts, burns, splinters, or other minor industrial injury. The employer is not required to provide a SCIF 3301 or complete the SCIF 3067 when injuries of this type occur.

What is an Aggravation of a Pre-Existing Condition?

Under California law, an injured employee who suffers an aggravation of a pre-existing disease or underlying condition has sustained a new injury or illness. For example, if an employee has arthritic deterioration in his or her knee, and then falls on his or her knee and is unable to continue to work, the fall constitutes an injury. An "aggravation" causes a temporary or permanent increase in disability, creates a new need for medical treatment, or requires a change in the existing course of treatment.

Symptoms that are a "flare-up" or "recurrence," also sometimes referred to as an "exacerbation" of a previous industrial injury or illness, do not constitute a new injury. Responsibility for compensation would lie with the employer where the original injury was sustained.

What is the "Date of Injury"?

It is necessary to establish the date of injury for every claim filed. In a specific injury, the date of injury is the date the incident or exposure occurred (LC §5411). In a cumulative injury or occupational illness, the date of injury (for statute of limitation purposes) is the date when the injured employee first suffered disability from the exposure or knew, or with the exercise of reasonable diligence should have known, that the disability was caused by present or previous employment (LC §5412). An injured employee may have had symptoms resulting from the cumulative injury or the disease for a period of time, even years, before the date of injury.

The date of injury is important, because it determines:

- The statute of limitations for particular procedures within the workers compensation system;
- The regulations that will apply to the employee's injury;
- The compensation rate for the employee's injury; and
- The employer who is liable for the claim.

Important time limits controlled by the date of injury include how long an injured employee has to:

- File a workers' compensation claim;
- File a claim with the WCAB; and
- Request vocational rehabilitation services.

Is the Injury Work Related?

An injured employee has the burden of proof to show by a preponderance of the evidence that an injury is work related. Work activities need not be the sole cause of the injury, or even the primary cause. It is enough that the employment contributed to the injury to any significant degree. The only exception to this rule is in the case of psychiatric injuries, which require the actual events of employment to be the predominant cause among all of the combined causes of the psychiatric injury.

The question of whether an injury is work related is divided into two parts (LC §3600):

1. Did the injury "arise out of employment" and
2. Did the injury "occur in the course of employment"?

Arising out of Employment (AOE)

The physician provides direct evidence on whether, and how, the activities of work have led to the current injury, and answers the question of whether the injury meets the AOE criteria. In a specific injury, establishing AOE may involve giving a description of an incident and the resulting damage to the patient.

Occurring in the Course of Employment (COE)

The question of whether an injury occurred in the COE involves the circumstances of the accident or exposure. If COE is in dispute, a workers' compensation judge will decide the issue based on legal precedents and evidence offered by the employee, employer, and witnesses. The WCAB and the California Appellate Court have established that activities that are not part of the employee's job description but are "incidental" to the employment, are included in the COE. For example, employees who travel on behalf of their employer are generally covered by workers' compensation for the entire travel period, unless there is "substantial deviation" from the agreed upon route. Injuries sustained in employer-owned parking lots, in the rest room, or while the employee is on the premises for a rest break or lunch period are usually compensable under workers' compensation.

How Risk Factors Effect the Cause of the Injury?

A basic principle of workers' compensation law is that the employer "takes the employee as he finds him." The employer can't avoid liability for a work-related injury by claiming that the injury would not have happened if the injured employee had been in a different physical or emotional condition before the accident. Employees who smoke, drink, or do not get physical exercise are still entitled to workers' compensation benefits for their occupational injuries.

Presumptions About Work-Related Injuries

The Legislature has defined certain conditions (such as hernias, pneumonia, tuberculosis, heart disease, and cancer) as work-related injuries when they affect certain employees, including fire fighters, forestry officers, peace officers, and correctional employees. These presumptions cover conditions that manifest or develop during the period of active service. The laws sometimes include a rebuttable presumption that those conditions are work related. The effect of this presumption is to shift the burden of proof to the employer, who must then show that the condition is not caused by work. If the employer does not meet that burden, workers' compensation benefits must be awarded.

Compensation for Psychiatric Injuries

A psychiatric injury is compensable if it is a diagnosed mental disorder that causes disability or need for medical treatment. For injuries occurring on or after July 17, 1993, an injured employee must prove that the "actual events of employment" were the "predominant cause" among all of the combined causes of the psychiatric injury.

For psychiatric injuries that result from a violent act, or from direct exposure to a signifcant violent act, the actual events of employment must have been a "substantial cause" of the injury, in that they contributed at least 35 percent of the causation from all sources combined (LC §3208.3).

A psychiatric injury is not compensable unless the injured employee was employed by his or her employer for at least six months, which need not have been continuous. This requirement does not apply if the injury was caused by a sudden and extraordinary employment condition.

Claims for psychiatric injuries that were substantially caused by "lawful, nondiscriminatory, good faith personnel actions" are prohibited. This prohibition is meant to eliminate claims that were filed by injured employees who suffered stress resulting from personnel actions, such as being served with an Adverse Action, or being placed on Leave Control.

Causation for Psychiatric Injuries

The physician must take a more detailed history when doing a psychiatric evaluation because there are more restrictions on workers' compensation psychiatric claims. The examiner needs to address issues such as the injured employee's developmental history, personal problems, job satisfaction, performance reviews, and reasons for leaving other positions. A psychiatric history should include the injured employee's level of functioning in home, academic, and social settings. In determining whether there is workplace causation for psychiatric injuries, the examiner will have to rely on depositions, co-workers' statements, personnel records, psychometric test data, academic and military records, and interviews with family members. The examination can take longer than a simple medical examination because the examiner must review this additional data and determine the injured employee's potential exaggeration or minimization of symptoms, motivation for retraining, and sources of secondary gain.

Claims Filed after Notice of Termination or Layoff

The 1993 workers' compensation reform prohibits compensation for claims that were filed after a notice of termination or layoff, unless the injured employee demonstrates that one or more of the following conditions apply (LC §3600):

- The employer had notice of the injury before the notice of termination or layoff;
- The employee's medical records existing before the notice of termination or layoff contain evidence of the injury;
- The date of injury is subsequent to the date of the notice of termination or layoff, but before the effective date, or
- The injury is a cumulative trauma injury or disease that is discovered after the notice of termination or layoff. (This provision allows post-termination claims for cumulative injuries or occupational illnesses that do not manifest themselves until after the injured employee has left the job. The date of injury in these cases is the date when the in-

jured employee first suffered disability from the exposure, and either knew, or, in the exercise of reasonable diligence, should have known, that the disability was caused by prior employment).

If termination or layoff does not occur within 60 days of the notice, then the prohibition against post-termination claims does not apply. Frequent notices of termination or layoff are considered a "bad-faith" personnel action and are exempted from this prohibition.

What is an Impairment or Disability?

When the body, or organ, or part of the body loses all or part of its function, compared to its previous level of functioning, it is said to be impaired. Impairment can be defined in purely medical terms and can be objectively measured. Examples of such impairments are loss of vision or hearing, or a decrease in range of motion. In the workers' compensation system, the physician performs a "disability evaluation," which is the basis for determining the nature and extent of impairment. The physician's disability evaluation is used to calculate a disability rating, which determines the amount of permanent disability benefits awarded to an injured employee.

When is an Employee's Condition Permanent and Stationary (P&S)?

An injured employee's medical condition is considered P&S after he or she has medically stabilized or when the condition has been stationary for a "reasonable period of time" (8 CCR §9735). P&S implies that the injured employee's condition has reached a point of maximum medical improvement, although some slight medical improvement may be anticipated in the future. It is also possible that deterioration may still occur in the future. The treating physician usually determines when an injured employee's condition becomes P&S, but often an evaluating physician's opinion is also sought.

When the injured employee's condition is deemed P&S, the injured employee is no longer entitled to temporary disability benefits. State Fund will determine whether the injured employee will receive any permanent disability (PD) benefits. The first payment of PD is due within 14 days of the final TD payment.

Providing for Future Medical Treatment

The use of the term P&S reflects that no significant change in the medical condition is anticipated in the short term. It does not mean that the injured employee will not have any further medical treatment. An injured employee may receive an award for continuing or future medical care, if treatment is needed:

- To maintain the injured employee's optimum condition;
- To relieve or cure the effects of the injury; or
- To relieve the effects of exacerbation's or recurrences which are reasonably expected due to the injured employee's condition.

Treating and evaluating physicians should carefully consider and calculate the need for continuing or future medical treatment and include as much detail on this as possible in their reports.

Who Rates Disabilities?

Treating and evaluating physicians perform a disability evaluation when the injury has become P&S, or has reached Maximum Medical Improvement (MMI). The factors of impairment listed in the disability evaluation report are used to calculate a permanent disability rating. The permanent disability rating is stated as a percentage, which equates to a monetary value that represents the employee's diminished future earning capacity. The treating or evaluating physician's report may also be used to determine the injured employee's need for future medical treatment and ability to return to work.

On unrepresented claims, the claims adjuster will rate the treating physician's disability evaluation report. If an unrepresented employee does not agree with the claims adjuster's rating of the treating physician's report, the injured employee may request a rating from the Disability Evaluation Unit (DEU). If the injured employee does not agree with the treating physician's report, then he or she may request and obtain a QME evaluation. All QME disability evaluations for unrepresented employees are rated by DEU raters.

On represented claims, all parties (claims adjuster, applicant or defense attorney, or other employer representative) rate the disability evaluation report(s) to come up with their own estimate of the injured employee's disability rating. The parties may agree to have a disability evaluation report rated by a DEU rater in order to facilitate settlement of the injured employee's case.

How to Obtain a Disability Evaluation?

The process for obtaining a physician's disability evaluation depends on the date of the injury and whether the injured employee has retained an attorney. An injured employee who is represented by an attorney is referred to as a represented employee and an employee with no attorney is referred to as an unrepresented employee.

Both the injured employee and the employer can dispute the treating physician's evaluation regarding the need for continuing medical care, medical eligibility for vocational rehabilitation, or the description of the disability. At this point, arrangements will be made for a comprehensive medical evaluation by an AME or a QME. The date of injury determines the medical-legal track that must be followed in order to obtain a disability evaluation (see LC §4060 - 4062.2).

Temporary Work Restrictions

Many injured employees are able to perform some, but not all, of their job tasks at some point during the healing process. When the treating physician believes that it is possible for an injured employee to return to work in some capacity, he or she is required to delineate

the tasks or working conditions that must be avoided. It is essential that the physician have a clear understanding of the work being returned to, and that the physician makes the restrictions clear in that context.

Permanent Work Restrictions

Permanent work restrictions are an important consideration in the return-to-work process. Although, the evaluating physician needs a good understanding of the injured employee's occupation to write the work restrictions, the restrictions are usually described in terms of the functional limitations, rather than referring specifically to the injured employee's current job. For example, the physician's report would state "may do work requiring repetitive motions of the hand and fingers, such as keyboarding, no more than 45 minutes out of every hour, and may not work on tasks requiring prolonged or repetitive use of pinch grip," rather than simply "limit keyboard operation to 45 minutes per hour." This protects the employee from being given a task that the injured employee should not do.

Injury Aggravates a Pre-Existing Condition

Apportionment becomes an issue when an injury aggravates a pre-existing condition. If cumulative or specific trauma at work creates new symptoms, a new need for medical treatment or TD benefits, or results in additional work restrictions or further loss of capacity, then the injured employee is entitled to file a workers' compensation claim. The workplace activity was the cause of this new TD. If, after the healing period, the injured employee's condition returns to the level present before the aggravation, then the aggravating activity did not cause further PD. But if the injured employee's condition becomes P&S at a greater level of disability than had existed before the additional trauma, then the aggravating activity caused the additional disability.

Basic Principles of Apportionment

Effective April 19, 2004, regardless of date of injury, apportionment only applies to the PD and is based on causation. Any physician preparing a report on PD must address the issue of causation. The physician must make an apportionment determination by finding what approximate percentage of PD was caused by the direct result of the work-related injury and what portion was caused by other factors, including prior industrial injuries. The employer is only liable for the portion of disability directly caused by the work-related injury. Any prior PD awards to an injured employee are conclusively presumed to exist at the time of a subsequent injury.

WORKERS' COMPENSATION BENEFITS

Workers' Compensation provides the following benefits to injured employees:

Medical Treatment

Treatment that is reasonably required to cure or relieve the effects of the injury is paid for by the employer. This includes medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches and apparatus, including orthotic and prosthetic devices and services (LC §4600).

Medical treatment will be based on the American College of Occupational and Environmental Medicine's Occupational Medicine (ACOEM) Guidelines until the Administrative Director publishes the official Medical Treatment Utilization Schedule per LC §5307.27.

Lost Wages

Payments for lost work time paid to the injured employee while he or she is recovering from the injury or illness, and is unable to return to work. Payments must begin within 14 days of the employer's knowledge that a work-related injury or illness occurred, unless the employer contests the claim for workers' compensation benefits (LC §4656). An injured employee is considered temporarily disabled until he or she has returned to work full duty or until the medical condition has reached the point of maximum medical improvement (permanent & stationary). There are several types of temporary disability benefit programs available to State employees under workers compensation.

Industrial Disability Leave (IDL)

Established by the Berryhill Total Compensation Act of 1975, IDL is a salary continuation program specifically designed as an alternative benefit program to Workers' Compensation Temporary Disability (TD). The legal authority for this program is found in Government Code Sections 19869 - 19877.1. To qualify for IDL benefits, an injured employee must be an active member of the California Public Employees' Retirement System (CalPERS) or the California State Teachers Retirement System (CalSTRS).

IDL benefits are paid in lieu of TD. An injured employee's appeal regarding IDL benefits is within the jurisdiction of the WCAB with regard to the basic time-frames, amounts, and penalties relevant to that portion of the IDL payment that is equal to the TD payment.

Lost time on the date of injury is paid as administrative time off, however medical verification is required. Thereafter, an injured employee will serve a waiting period of three-calendar days (or 24 working hours). The waiting period need not be consecutive days. Partial days of absence for doctor appointments or authorized periods of disability may be accumulated to equal full days and charged to the 24 hour waiting period. The waiting period is waived if the injured employee is hospitalized, if the injury was caused by a criminal act of violence, or the injured employee is disabled more than 14 calendar days.

IDL benefit payments are based on the injured employee's current wages. For the first 22 working days of disability, an injured employee receives full net salary. Thereafter, the payments are based on two-thirds of the injured employee's normal gross salary without any reduction for taxes. Even though IDL is not taxable, the gross amount for IDL during the first 22 working days is reduced by the amount that would have been taken for taxes

(federal, Social Security, Medicare, and state taxes). This is called the "reduced gross" and is the amount reflected on the warrant register, as well as on the earnings statement. Because the statutory intent of the IDL benefit is a continuation of the injured employee's net compensation, this reduced gross is calculated for the period that he or she is disabled and unable to work.

The only mandatory deduction taken from an IDL payment is the retirement contribution, which is based on the employee's actual gross income. In addition, IDL payments may be subject to the following deductions: survivor's benefits, accounts receivable, child support, spousal support, conservatee support, and CalPERS arrears contributions. All voluntary deductions continue, except pre-taxed deductions, unless the injured employee cancels them. Pre-tax deductions (e.g., deferred compensation, tax-sheltered annuities, and health/dental premium co-pays) can only be deducted from IDL supplementation provided the supplementation gross is sufficient to cover the deductions.

IDL benefits are payable for a maximum of 52 weeks, or 365 calendar days, within a two-year period, from the first day of disability or first time lost due to the injury or illness. Any time paid as IDL, whether one hour or eight hours, constitutes one day of IDL applied to the maximum time limits.

Industrial Disability Leave with Supplementation (IDL/S)

All excluded employees and rank-and-file employees in all Bargaining Units (except Bargaining Unit 5) who meet the eligibility requirements for IDL are also eligible for IDL/S. IDL/S allows an injured employee to supplement his or her IDL payment up to his or her full net pay with available leave credits.

When an injury or illness has been determined to be work related and workers' compensation benefits are approved, an injured employee will be given 15 calendar days in which to choose IDL or IDL/S. The 15 calendar day "election period" commences on the date that the department informs the employee that he or she is eligible for benefits. Injured employees who fail to make an election within 15 calendar days will be placed on IDL without supplementation. Injured employees who fail to make an election in a timely manner forfeit the right to supplement the IDL benefit at any future time for this disability.

If an injured employee elects IDL/S, then he or she may choose to supplement at the level sufficient to yield an income which approximates his or her full net pay or at a level that is less than that amount. However, supplementation is not applicable for the first 22 days because the injured employee receives full net pay during that period. Once the supplementation level is selected, the injured employee may elect to decrease the amount at any point in the future, but he or she may not elect to increase the amount. Any subsequent reduction in the supplementation amount will be made on a prospective basis only. Levels cannot include fractions of hours.

If an injured employee is on IDL a portion of the month, and the amount of supplementation selected exceeds the amount necessary to obtain full net pay, the personnel office must

adjust the supplementation amount to ensure that the injured employee's disability payment does not exceed full net pay. "Full net pay," means the injured employee's gross salary minus federal and state taxes, OASDI/Medicare, and Retirement. Miscellaneous deductions will not be factored into the calculation of the injured employee's full net pay. Income received from supplementation is taxable and will be reported on the employee's W-2 Form at the end of the year. Federal and state taxes will be based on the current flat tax rate.

Enhanced Industrial Disability Leave (EIDL)

EIDL is full net salary for one to three years, depending on the specific contract and Memo Of Understanding (MOU). EIDL was established in 1984 through MOUs between the State and exclusive representatives for rank-and-file employees in specific bargaining units. Government Code Section 19871.2 provides the authority for excluded employees to have this benefit also. Currently, employees in Bargaining Units 1, 3, 4, 6, 7, 8, 11, 12, 13, 15, 16, 17, 18, 19, 20, and excluded employees are eligible for this benefit if they suffer a qualifying illness or injury.

To qualify for EIDL benefits, the injured employee must be temporarily disabled as a result of an injury incurred in the official performance of his or her duties. Such injury must be a physical injury that has been directly and specifically caused by:

- An assault by an inmate, ward, or parolee under the jurisdiction of the California Department of Corrections and Rehabilitation; or

- Responding to, returning from, or fighting an "active fire"; or

- A criminal act of violence against a peace officer who was performing
  In the line of duty (a criminal act of violence is an act which would constitute a misdemeanor or felony if pursued to conviction);

- A domestic animal attack while the peace officer was performing in the line of duty;

- An assault by a resident, inmate, patient, client, or member under the Jurisdiction of the Department of Developmental Services, the Department of Mental Health, or the Department of Veterans' Affairs;

- An injury incurred while at a crime scene and while performing the official duties of a Department of Justice Bureau of Forensic Services crime scene responder;

- Involvement in an automobile accident while performing a driving examination, or as a result of a criminal act of violence while performing the said duties of a Department of Motor Vehicle licensing examiner; or

- An assault while performing the said duties of the classification of Inspectors, Department of Consumer Affairs and Program Representative, and Bureau of Automotive Repair.

The department's appointing power or his or her designee has the final decision regarding an injured employee's eligibility for EIDL based on the specific circumstances of each case. EIDL is an extension of IDL and has most of the same requirements. However, permanent intermittent employees in Bargaining Unit 6 may be entitled to EIDL even if they are not members of CalPERS or CalSTRS. As with IDL, injured employees must serve a waiting period of three-calendar days (or 24 working hours). This waiting period is waived if the injured employee is hospitalized, unable to work for more than 14 calendar days, or the injury is the result of a criminal act of violence.

Temporary Disability (TD)

TD is payment for lost work time paid to an injured employee while he or she is being treated and is unable to return to work. An injured employee will receive TD benefits if he or she does not qualify for or exhausts eligibility for IDL. Before receiving TD an injured employee will serve a waiting period of three calendar days. The three day waiting period is waived when the injured employee is hospitalized during the waiting period, disabled as a result of a criminal act of violence, or the loss of time exceeds 14 days. Administrative Time Off (ATO) is paid on the date of injury if the injured employee provides medical documentation verifying the time loss. State Fund will issue TD payments directly to the injured employee every two weeks. The payment continues until the injured employee returns back to work full duty or his or her condition is determined to be permanent & stationary. For dates of injury occurring on or after April 19, 2004, there is a limitation of 104 weeks that TD is payable (LC§ 4650).

TD payments are not taxed and are generally equal to two-thirds of the injured employee's average weekly earnings at the time of the injury, up to a ceiling determined by the Legislature.

Injured employees do not receive total temporary disability benefits once they return to work. However, an injured employee may qualify for temporary partial disability benefits if they return to work but are medically unable to work as many hours as they did at the time of injury.

Temporary Disability with Supplementation (TD/S)

The State offers injured employees the option to supplement TD payments with his or her leave credits to allow him or her to receive a benefit that is comparable to their full pay. Injured employees who have sufficient leave credits to cover their absence can supplement their TD payments. Leave credits include any accumulated sick leave, vacation, annual leave, and compensated overtime. In addition, any applicable holidays that fall within the pay period and the personal holiday can also be used to supplement.

TD payments are issued by SCIF to the injured employee and have no mandatory or voluntary deductions withheld. The supplementation payments, which are paychecks issued by the State Controller's Office, are paid by the employer and are subject to all mandatory deductions including taxes, retirement contributions, garnishments, and union dues. Voluntary deductions, such as health, dental, and vision benefits or life insurance can also be withheld. However, deductions can only be made as long as there are sufficient leave credits. Mandatory deductions will have priority over voluntary deductions.

An injured employee can choose not to supplement his or her TD payment. In this event an injured employee is entitled to a continuation of health, dental, and vision benefits. If an employee contribution is due, arrangements must be made by the department to collect that portion directly from the injured employee (see Personnel Management Liaison 2000-035).

Labor Code Section 4800

Labor Code Section 4800 is a special benefit available only to an eligible peace officer that is a member of the Department of Justice (DOJ) falling within the "state peace officer or firefighter" classification. An officer who is disabled by an injury arising out of and in the course of his or her duties is entitled, regardless of his or her period of service with DOJ, to leave of absence while disabled, without loss of salary. Full salary is paid in lieu of disability payments under this Labor Code Section and is for a period not to exceed one year.

This section applies only to members of DOJ whose principal duties consist of active law enforcement and does not apply to persons employed by DOJ whose principle duties do not fall within the scope of active law enforcement service.

This section does not apply to periods of disability, which occur subsequent to termination of employment by resignation, retirement, or dismissal. When this section does not apply, the officer is eligible for those benefits that would apply if this section had not been enacted.

Labor Code 4800.5

Labor Code Section 4800.5 is a special benefit available to eligible peace officers. It provides for up to one year of full pay for injuries that occur in the line of duty. A sworn member of the Department of the California Highway Patrol (CHP) when disabled by a single injury, excluding disabilities that are the result of cumulative trauma or cumulative injuries, arising out of and in the course of his or her duties, is entitled, regardless of his or her period of service with CHP, to leave of absence while disabled without loss of salary. The disabled officer will receive his or her full salary in lieu of disability payments under this section for a period not to exceed one year.

This section applies only to members of CHP whose principle duties consist of active law enforcement and does not apply to persons whose duties do not fall within the scope of active law enforcement service.

Benefits payable for eligible sworn members of CHP whose disability is solely the result of cumulative trauma shall be limited to the actual period of entitlement to temporary disability or maintenance allowance, or for one year, whichever is less.

This section does not apply to periods of disability that occur subsequent to termination of employment by resignation, retirement, or dismissal.

The Workers' Compensation Appeals Board (WCAB) may determine, upon request of any party, whether or not the disability referred to in this section arose out of and in the course of duty. In any action in which a dispute exists regarding the nature of the injury or the period of temporary disability or entitlements, the WCAB has the jurisdiction to award and enforce payment of these benefits.

Permanent Disability

Permanent Disability (PD) payments are made to compensate an injured employee for his or her diminished future earnings capacity because he or she has a permanent impairment or limitation as a result of their injury (LC§4061). An injured employee can receive PD payments and return to work full duty.

However, the PD payments can be reduced by 15 percent if the employer offers the injured employee regular, modified, or alternative work within 60 days of his or her permanent & stationary date. The modified or alternative work must pay at least 85 percent of the date of injury salary, last at least 12 months, be within a reasonable commuting distance, and accommodate the work restrictions. The 15 percent reduction takes place from the date of the offer and affects future payments. If the employer does not offer regular, modified, or alternative work then future PD payments are increased by 15 percent after the 60 day period has expired.

Vocational Rehabilitation Services

Vocational Rehabilitation Services apply to dates of injury that occurred on or before December 31, 2003. An injured employee may be eligible for services if he or she is a qualified injured worker (QIW) and unable to return to his or her usual and customary occupation. These benefits may include modified or alternative work assignments, job placement, on-the-job training, self-employment, and retraining. An injured employee may be entitled to receive a vocational rehabilitation maintenance allowance (VRMA, see LC§4635) while participating in vocational rehabilitation.

Note: Vocational rehabilitation services have been eliminated effective January 1, 2004 and replaced with supplemental job displacement benefits (SJDB).

Vocational Rehabilitation Maintenance Allowance (VRMA)

If the injured employee's condition is permanent and stationary, and he or she is participating in vocational rehabilitation, then he or she will receive VRMA for up to 52 weeks. This period can be extended if the employer did not provide benefits during a period of dispute over medical eligibility, or if the employer delayed in providing vocational rehabilitation services. The amount of VRMA is determined by Legislature. Additionally, an injured employee may supplement his or her VRMA payment with available leave credits up to an income which approximates his or her full net pay.

In some cases, an injured employee may be eligible to receive IDL, 4800 time, or 4800.5 time while participating in vocational rehabilitation provided benefit eligibility has not been exhausted.

Supplemental Job Displacement Benefit (SJDB)

For dates of injury occurring on or after January 1, 2004, an injured employee may be eligible for the SJDB. The SJDB is a voucher for a retraining or skill enhancement program at a state approved or accredited school. The voucher can range in value up to $10,000 based on the level of an injured employee's permanent disability and can be used towards tuition, fees, books, vocational rehabilitation counselor services, and other related expenses. There is no longer a provision for VRMA.

To be eligible an injured employee must not have been returned to work with his or her employer within 60 days after the temporary disability period ends and he or she must have a permanent disability. However the employer is not liable for the SJDB if they offer the injured employee modified or alternative work within 30 days of his or her temporary disability period. The modified or alternative work must pay at least 85 percent of the date of injury salary, last at least 12 months, be within a reasonable commuting distance, and accommodate the work restrictions.

Death Benefit

Death Benefit payments are made to surviving total and partial dependents of the deceased. Once dependency is established the benefit is paid out in installments to the dependents at the decedent's TD rate, until the total benefit is paid or a minor child turns 18-years of age (LC§4700). The employer is responsible for reasonable burial expenses not to exceed $5,000 (LC§4701).

Effective January 1, 2003, dependent children who are mentally or physically incapacitated from earning will continue receiving benefits until their death.

RETURNING AN INJURED EMPLOYEE TO WORK

It is the goal of the State of California, under the Master Agreement, to restore each injured employee to a useful place in the community, while making the best use of taxpayer money. This section discusses the interface of vocational rehabilitation with the Americans with Disabilities Act (ADA) and the California Fair Employment and Housing Act (FEHA).

Vocational Rehabilitation

In 1974, the Legislature mandated that qualified injured workers who were injured on or after January 1, 1975, must be offered vocational rehabilitation benefits. The goal of vocational rehabilitation is to enable an injured employee to return to suitable gainful employment. This means employment that can be reasonably attained and is consistent with the employee's residual disability, vocational interests and aptitudes, and pre-injury earning capacity (although the new job is not required to match previous earnings). Vocational rehabilitation services may include modification cost for the injured employee's current job, direct placement, on-the-job training, self-employment, or retraining. Vocational rehabilitation benefits are only provided to injured employees with injuries occurring before January 1, 2004.

Vocational rehabilitation services, or modified or alternative work assignments, must be made available to qualified injured workers who meet the following requirements (LC §5635):

Medical Eligibility: The injured employee must be expected to be permanently disabled as the result of the injury. That is, the disability, by itself or in combination with pre-existing disabilities or other factors such as the injured employee's age, will permanently keep him or her from engaging in the usual occupation, or in the position performed at the time of the injury. The evaluating physician determines medical eligibility for vocational services.

Vocational Feasibility: When factors like age and prior disability are taken into account, the injured employee can be expected to find employment that is economically feasible after completing the vocational rehabilitation plan.

For injuries that occurred on or after January 1, 1994, the employer may meet vocational rehabilitation requirements by offering an injured employee a permanent modified or alternative work assignment. The employer makes this offer using the Notice of Offer of Modified or Alternative Work (DWC RU-94 or SCIF 3236). The offer needs to be made within 10 days from the physician's determination that an injured employee is medically eligible for vocational rehabilitation or prior to the assignment of an outside rehabilitation coordinator. These outside vendors are referred to as Qualified Rehabilitation Representatives (QRR).

If the employer is unable to offer permanent modified or alternative work, a QRR will be assigned to determine if the employee meets vocational feasibility requirements. The State Fund vocational rehabilitation coordinator (VRC) will send the employee a list of three

QRRs from which to choose. If the VRC and injured employee cannot agree on a QRR, then the Rehabilitation Unit of DWC will appoint an Independent Vocational Evaluator to make a determination on vocational feasibility. The employee and the QRR will jointly develop a vocational rehabilitation plan aimed at returning the employee to suitable gainful employment. In most cases, the employer's liability for the complete vocational rehabilitation benefit is limited to $16,000.00. Although the employer is required to provide vocational rehabilitation benefits, the injured employee does not have to accept or participate in vocational rehabilitation.

Modified and Alternative Work Assignments

The 1989 workers' compensation reforms made modified and alternative work assignments a high priority as a way to help injured employees return to work. A modified work assignment can involve a change to the job that will enable the injured employee to perform in that position. Some examples of modifications include:

- Modifying the workstation so that the job can be performed seated, instead of standing;
- Modifying the content of the work to exclude tasks that the injured employee can no longer perform;
- Moving the injured employee to a different work location to avoid dusts or other irritants; or
- Reducing the amount of time spent on a particular task (i.e. 15 minutes rest for every hour of keyboard work or other repetitive hand or finger motion).

An alternative work assignment involves placing an injured employee in another position within the department. To qualify as an alternative work assignment under vocational rehabilitation, the assignment must provide:

- Wages and compensation within 15 percent of the amount that the injured employee was being paid at the time of the injury;
- Must be within a reasonable commuting distance of the injured employee's residence at the time of injury;
- The assignment must be for a period of at least 12 months; and
- The employee must be able to perform the essential job functions of the assignment.

However, an employer may offer a position not meeting all of the above criteria. If the employee accepts the position, then a request can be made to the Rehabilitation Unit to terminate vocational rehabilitation services.

The RTWC Role in Vocational Rehabilitation

The treating physician can determine that the injured employee is medically eligible for vocational rehabilitation at any time in the course of the claim. It is important to make this determination as soon as it is reasonably clear the injured worker is unlikely to be able to return to the pre-injury job (without some modification). If the physician has not already

identified the injured employee as medically eligible by the time he or she has been totally disabled for 90 days, the employer is required to contact the treating physician for a medical eligibility determination.

The RTWC should furnish State Fund with the injured employee's job analysis that lists the physical requirements and essential functions of his or her job. State Fund will send this information to the treating physician who will estimate the injured employee's current and potential functional limitation, his or her ability to participate in vocational rehabilitation services, and his or her ability to engage in light or modified work assignments. If the treating physician cannot make the determination at that time, the physician must report to both the employer and the injured employee at least every 60 days, until the determination can be made.

The Labor Code's Nondiscrimination Policy

In addition to protection under ADA and FEHA, LC §132a states, "It is the declared policy of this state that there should not be discrimination against employees who are injured in the course and scope of their employment." It is a misdemeanor for any employer to discharge, threaten to discharge or discriminate in any manner against an employee for:

- Filing or stating the intention to file a claim for employees' compensation;
- Filing or stating the intention to file an application for adjudication;
- Receiving an employees' compensation rating, and, or settlement; or
- Testifying or stating the intention to testify in another employee's case before the WCAB.

An injured employee who has suffered discrimination for any of these reasons may file a petition for award under LC§132a with the WCAB (which will refer misdemeanor charges to the Division of Labor Standards Enforcement), and is entitled to increased compensation, reinstatement, and reimbursement for lost wages and work benefits caused by the acts of the employer.

Discrimination - It's Against the Law

The Fair Employment and Housing Act (FEHA) passed in 1973. It’s employment sections protect against discrimination in the workplace on the basis of race, color, ancestry, religious creed, sex, marital status, age, medical condition, mental and physical disabilities, and pregnancy. FEHA also offered a family and medical leave policy in California long before such a measure was enacted at the federal level. It is FEHA's coverage of mental and physical disabilities that is relevant in workers' compensation cases.

In 1993, the State Legislature brought FEHA into conformity with the federal Americans with Disabilities Act (ADA). The two acts essentially function to give overlapping coverage to employees with disabilities in the workplace, with FEHA providing broader coverage.

All State of California employees are covered under FEHA regardless of the origin of the disability. Under State law, complaints can be filed under either ADA, FEHA, or jointly, and Department of Fair Employment and Housing attorneys have explicit standing to jointly pursue such claims in California with Equal Employment Opportunity Commission staff. Historically, FEHA actions have rarely been taken in conjunction with workers' compensation cases. This is changing as employees with disabilities make claims of discrimination or lack of accommodation under FEHA which goes far beyond the requirements in workers' compensation statutes to require job modification or provision of alternative work.

ACRONYMS

ACOEM - American College of Occupational and Environmental Medicine's Occupational Medicine

ADA - Americans with Disabilities Act

AME – Agreed Medical Evaluator

AOE – Arising Out of Employment

CalPERS - California Public Employees' Retirement System

CalSTRS - State Teachers' Retirement System

CHP - Department of California Highway Patrol

COE – Course of Employment

DEU – Disability Evaluation Unit

DIR – Department of Industrial Relations

DOJ - Department of Justice

DPA - Department of Personnel Administration

DWC – Division of Workers' Compensation

EEOC - Equal Employment Opportunity Commission

EIDL - Enhanced Industrial Disability Leave

FEHA – Fair Employment and Housing Act

IDL - Industrial Disability Leave

IDL/S - Industrial Disability Leave with Supplementation

IMC - Independent Medical Council

IVE – Independent Vocational Evaluator

LC – Labor Code

MMI – Maximum Medical Improvement

PD – Permanent Disability

P&S – Permanent and Stationary

QID - Qualified Individual with a Disability

QIW – Qualified Injured Worker

QME – Qualified Medical Evaluator

QRR – Qualified Rehabilitation Representative

RTWC – Return-To-Work Coordinator

SAM – State Administration Manual

SCIF - State Compensation Insurance Fund

SCO - State Controller's Office

SJDB – Supplemental Job Displacement Benefit

SPB – State Personnel Board

TD - Temporary Disability

TD/S - Temporary Disability with Supplementation

TPA – Third-Party Administrator

WCAB - Workers' Compensation Appeals Board

WCP – Workers' Compensation Program

VRC – Vocational Rehabilitation Coordinator

VRMA – Vocational Rehabilitation Maintenance Allowance